



**FY 2019**  
**(09/01/2018 – 08/31/2019)**  
**Renewal Application Packet**  
**For HIV State Services (SS)**

<http://www.dshs.texas.gov/hivstd/funding/default.shtm>

Issue Date: February 1, 2018

Due Date: **February 16, 2018**

*Contract Management Section*  
*Department of State Health Services*  
1100 W. 49<sup>th</sup> Street  
Austin, Texas 78756-3199

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### Department of State Health Services (DSHS)

**FORM A: Face Page** This form requests basic information about the applicant and project, including the signature of the authorized representative. The face page is the cover page of the renewal and shall be completed in its entirety. Signature of face page certifies to all DSHS and program assurances listed in this renewal document.

RESPONDENT INFORMATION	
1) <b>LEGAL BUSINESS NAME:</b>	
2) <b>MAILING Address Information</b> (include mailing address, street, city, county, state and 9-digit zip code): <span style="float: right;">Check if address change <input type="checkbox"/></span>	
3) <b>PAYEE Name and Mailing Address, including 9-digit zip code</b> (if different from above): <span style="float: right;">Check if address change <input type="checkbox"/></span>	
4) <b>DUNS Number (9-digit) required if receiving federal funds:</b>	
5) <b>Federal Tax ID No. (9-digit), State of Texas Comptroller Vendor ID Number (14-digit) or Social Security Number (9-digit):</b>  <i>*The respondent acknowledges, understands and agrees that the respondent's choice to use a social security number as the vendor identification number for the contract, may result in the social security number being made public via state open records requests.</i>	
6) <b>TYPE OF ENTITY</b> (check all that apply): <div style="display: flex; flex-wrap: wrap;"> <div style="width: 33%;"><input type="checkbox"/> City</div> <div style="width: 33%;"><input type="checkbox"/> Nonprofit Organization*</div> <div style="width: 33%;"><input type="checkbox"/> Individual</div> <div style="width: 33%;"><input type="checkbox"/> County</div> <div style="width: 33%;"><input type="checkbox"/> For Profit Organization*</div> <div style="width: 33%;"><input type="checkbox"/> Federally Qualified Health Centers</div> <div style="width: 33%;"><input type="checkbox"/> Other Political Subdivision</div> <div style="width: 33%;"><input type="checkbox"/> HUB Certified</div> <div style="width: 33%;"><input type="checkbox"/> State Controlled Institution of Higher Learning</div> <div style="width: 33%;"><input type="checkbox"/> State Agency</div> <div style="width: 33%;"><input type="checkbox"/> Community-Based Organization</div> <div style="width: 33%;"><input type="checkbox"/> Hospital</div> <div style="width: 33%;"><input type="checkbox"/> Indian Tribe</div> <div style="width: 33%;"><input type="checkbox"/> Minority Organization</div> <div style="width: 33%;"><input type="checkbox"/> Private</div> <div style="width: 33%;"><input type="checkbox"/> Faith Based (Nonprofit Org)</div> <div style="width: 33%;"><input type="checkbox"/> Other (specify): _____</div> </div> <i>*If incorporated, provide 10-digit charter number assigned by Secretary of State: _____</i>	
7) <b>PROPOSED BUDGET PERIOD:</b> <span style="margin-left: 50px;"><b>Start Date:</b> 09/01/2018</span> <span style="margin-left: 50px;"><b>End Date:</b> 08/31/2019</span>	
8) <b>COUNTIES SERVED BY PROJECT:</b>	
9) <b>AMOUNT OF FUNDING REQUESTED:</b>	11) <b>PROJECT CONTACT PERSON</b>
10) <b>PROJECTED EXPENDITURES</b>  Does respondent's projected federal expenditures exceed \$500,000, or its projected state expenditures exceed \$500,000, for respondent's <u>current fiscal year</u> (excluding amount requested in line 9 above)? **  Yes <input type="checkbox"/> No <input type="checkbox"/>  <i>**Projected expenditures should include anticipated expenditures under all federal grants including "pass through" federal funds from all state agencies, or all anticipated expenditures under state grants, as applicable.</i>	Name: Phone: Fax: Email:
12) <b>FINANCIAL OFFICER</b>	
Name: Phone: Fax: Email:	
The facts affirmed by me in this proposal are truthful and I warrant the respondent is in compliance with the assurances and certifications contained in <b>APPENDIX B: DSHS Assurances and Certifications</b> . I understand the truthfulness of the facts affirmed herein and the continuing compliance with these requirements are conditions precedent to the award of a contract. This document has been duly authorized by the governing body of the respondent and I (the person signing below) am authorized to represent the respondent.	
13) <b>DOCUSIGN SIGNATURE AUTHORITY</b>  Name: Title:	14) <b>DOCUSIGN ADMINISTRATIVE CONTACT</b>  Name: Email:

Phone:  
Fax:  
Email:

15) DATE

## FORM A: FACE PAGE Instructions

This form provides basic information about the applicant and the proposed project with the DSHS, including the signature of the authorized representative. It is the cover page of the renewal application and is required to be completed. Signature affirms that the facts contained in the applicant's response are truthful and that the applicant is in compliance with the assurances and certifications contained in the identified Competitive Request for Proposal and the original DSHS contract, any renewal(s) or amendment(s). Applicant acknowledges that continued compliance is a condition for the renewal of a contract. Please follow the instructions below to complete the face page form and return with the applicant's response.

- 1) **LEGAL BUSINESS NAME** - Enter the legal name of the applicant.
- 2) **MAILING ADDRESS INFORMATION** - Enter the applicant's complete physical address and mailing address, city, county, state, and 9-digit zip code.
- 3) **PAYEE NAME AND MAILING ADDRESS** - Payee – Entity involved in a contractual relationship with applicant to receive payment for services rendered by applicant and to maintain the accounting records for the contract; i.e., fiscal agent. Enter the PAYEE's name and mailing address, including 9-digit zip code, if PAYEE is different from the applicant. The PAYEE is the corporation, entity or vendor who will be receiving payments.
- 4) **DUNS Number** – 9- digit Dun and Bradstreet Data Universal Numbering System (DUNS) number. . This number is required if receiving **ANY** federal funds and can be obtained at: <http://fedgov.dnb.com/webform>
- 5) **FEDERAL TAX ID or STATE OF TEXAS COMPTROLLER VENDOR ID NUMBER OR SOCIAL SECURITY NUMBER** - Enter the Federal Tax Identification Number (9-digit) or the Texas Vendor Identification Number assigned by the Texas State Comptroller (14-digit). \*The applicant acknowledges, understands and agrees the applicant's choice to use a social security number as its vendor identification number for the contract, may result in the social security number being made public via state open records requests.
- 6) **TYPE OF ENTITY** - Check the type of entity as defined by the Secretary of State at <http://www.sos.state.tx.us/corp/businessstructure.shtml> and/or the Texas State Comptroller at [https://fm.xcpa.state.tx.us/fmx/pubs/tins/tinsguide/2009-04/TINS\\_Guide\\_0409.pdf](https://fm.xcpa.state.tx.us/fmx/pubs/tins/tinsguide/2009-04/TINS_Guide_0409.pdf) and check all other boxes that describe the entity.

Historically Underutilized Business: A minority or women-owned business as defined by Texas Government Code, Title 10, Subtitle D, Chapter 2161. (<http://www.window.state.tx.us/procurement/prog/hub/>)

State Agency: an agency of the State of Texas as defined in Texas Government Code §2056.001.ii

Institutions of higher education as defined by §61.003 of the Education Code.

MINORITY ORGANIZATION is defined as an organization in which the Board of Directors is made up of 50% racial or ethnic minority members.

If a Non-Profit Corporation or For-Profit Corporation, provide the 10-digit charter number assigned by the Secretary of State.

- 7) **PROPOSED BUDGET PERIOD** - Budget period for this renewal application has been entered for you.
- 8) **COUNTIES SERVED BY PROJECT** - Enter the proposed counties served by the project. Include all counties in the HIV Administrative Services Area.
- 9) **AMOUNT OF FUNDING REQUESTED** - Enter the amount of funding per the allocation given from DSHS for proposed project activities (not including possible renewals). This amount must match column (1) row J from the BUDGET SUMMARY template(s) used for cost reimbursement budgets.
- 10) **PROJECTED EXPENDITURES** - If applicant's projected federal expenditures exceed \$500,000 or its projected state expenditures exceed \$500,000 for applicant's current fiscal year, applicant must arrange for a financial compliance audit (Single Audit).
- 11) **PROJECT CONTACT PERSON** - Enter the name, phone, fax, and email address of the person responsible for the proposed project.
- 12) **FINANCIAL OFFICER** - Enter the name, phone, fax, and email address of the person responsible for the financial aspects of the proposed project.
- 13) **AUTHORIZED REPRESENTATIVE** - Enter the name, title, phone, fax, and email address of the person authorized to represent the applicant. Check the "Check if change" box if the authorized representative is different from previous submission to DSHS.
- 14) **SIGNATURE OF AUTHORIZED REPRESENTATIVE** - The person authorized to represent the applicant must sign in this blank.
- 15) **DATE** - Enter the date the authorized representative signed this form.

## FORM B: CONTACT PERSON INFORMATION

Legal Name of Applicant: \_\_\_\_\_

*This form provides information about the appropriate program contacts in the applicant's organization. If any of the following information changes during the term of the contract, please notify the **Contract Manager and the HIV Care Services Group**.*

<b>Executive Director:</b> _____ <b>Title:</b> _____ <b>Phone:</b> _____ <b>Ext.</b> _____ <b>Fax:</b> _____ <b>E-mail:</b> _____	<b>Mailing Address (incl. street, city, county, state, &amp; zip):</b> _____ _____ _____ _____
<b>Project Contact:</b> _____ <b>Title:</b> _____ <b>Phone:</b> _____ <b>Ext.</b> _____ <b>Fax:</b> _____ <b>E-mail:</b> _____	<b>Mailing Address (incl. street, city, county, state, &amp; zip):</b> _____ _____ _____ _____
<b>Financial Reporting Contact:</b> _____ <b>Title:</b> _____ <b>Phone:</b> _____ <b>Ext.</b> _____ <b>Fax:</b> _____ <b>E-mail:</b> _____	<b>Mailing Address (incl. street, city, county, state, &amp; zip):</b> _____ _____ _____ _____
<b>Data Reporting Contact:</b> _____ <b>Title:</b> _____ <b>Phone:</b> _____ <b>Ext.</b> _____ <b>Fax:</b> _____ <b>E-mail:</b> _____	<b>Mailing Address (incl. street, city, county, state, &amp; zip):</b> _____ _____ _____ _____
<b>Clinical Services Contact:</b> _____ <b>Title:</b> _____ <b>Phone:</b> _____ <b>Ext.</b> _____ <b>Fax:</b> _____ <b>E-mail:</b> _____	<b>Mailing Address (incl. street, city, county, state, &amp; zip):</b> _____ _____ _____ _____
<b>Board Chairperson:</b> _____ <b>Title:</b> _____ <b>Phone:</b> _____ <b>Ext.</b> _____ <b>Fax:</b> _____ <b>E-mail:</b> _____	<b>Mailing Address (incl. street, city, county, state, &amp; zip):</b> _____ _____ _____ _____
<b>Emergency Contact:</b> _____ <b>Title:</b> _____ <b>Phone:</b> _____ <b>Ext.</b> _____ <b>Fax:</b> _____ <b>E-mail:</b> _____	<b>Mailing Address (incl. street, city, county, state, &amp; zip):</b> _____ _____ _____ _____

## **FORM C: HIV/SRVS PERFORMANCE MEASURE Guidelines**

With this renewal application, complete a separate proposed Table 1 for State Services and another for State-R funding. A total of two Table 1's must be completed per service provider. This follows ARIES contracts requirements.

Performance measures related to access and quality of care are included in the Ryan White contract and must be incorporated in updates to your comprehensive services plan either in the goals and objectives section or attached as an addendum to the plan. **Each AA is required to implement their comprehensive plans; it is required to implement the measures and report your progress in your quarterly report.**

### **REQUIRED PERFORMANCE MEASURES**

#### **Administrative Measures**

1. The Contractor will have subcontracted 100% of all State Services and State-R funds no later than thirty (30) calendar days after the first day of the contract year (by 9/30/18).
2. The contractor will submit a Subcontractor Data Sheet with an 8 categorical budget for each subcontractor receiving SS and State-R funds no later than 30 days after the first day of the contract year (by 9/30/18). Contractor shall implement a quality management (QM) system according to the Contractor's established QM Plan.
3. The Contractor will submit complete quarterly reports according to the Reporting Due Dates listed in this RW and SS contracts.
4. No less than ninety-five (95%) of the State Services and State-R funds will be expended by the end of the respective contract year.
5. Contractor shall provide clinical, programmatic and fiscal monitoring of all services delivered with State funds (whether directly or indirectly funded) according to Contractor's established internal policies, procedures, and schedules.
6. Contractor shall distribute all funds according to the service priorities and allocations established in its approved Comprehensive HIV Services Plan, and make reallocations in accordance to DSHS policy.

#### **State Services Measures**

1. Contractor shall ensure that no more than ten percent of the State Services and State-R allocation is expended by subcontractors for administrative costs.
2. Contractor shall use these funds to provide at least one service to **(Contractor must insert #)** unduplicated clients during Project Year (FY) 2019 (09/01/18 – 08/31/19). Objectives related to the # of persons and units to be provided must be reflected on Table 1: Services Priorities, Allocations, and Objectives.
3. Complete a proposed State Services Table 1 for each HSDA.
4. Contractor must enter complete and correct State Services contracts in ARIES and following required naming convention (18-19 SS, 18-19 State-R) no later than 30 days after the first day of the contract year (i.e., 9/30/18).
5. Contractor shall monitor the delivery of HIV services against the Estimated Units of Services and Unduplicated Clients to be served in the Initial ARIES contracts.

**ADAP Enrollment Worker (AEW) Measures:**

- The AEW will ensure:
  1.  $\geq 95\%$  of new enrollee and recertification ADAP applications are accepted by the THMP as complete upon initial submission;
  2.  $\geq 95\%$  of new enrollee applications are submitted within ten (10) business days of initial contact with the client;
  3.  $\geq 95\%$  of ADAP eligibility Re-certifications and self-attestations are completed on or before the lapse of ADAP program benefits
  4.  $\geq 95\%$  of applications are reviewed and signed by second AEW or supervisor before submission
  5. 100% of applications rejected or held by the THMP because of missing or inaccurate documentation are followed-up with the applicant within two (2) business days of notice from the THMP; All efforts made on behalf of the applicant are documented in the appropriate file (e.g. medical record) within one (1) business day of occurrence;
- Agency will provide aggregated data regarding AEW performance measures to the DSHS Care Services Group as via quarterly reporting.

## **FORM D: HIV/SRVS WORK PLAN Guidelines**

For each response please consider the improvement of service delivery systems in your HASA or specific HSDA's.

1. Identify activities the Administrative Agency has planned for FY 2018-2019 related to planning, data, quality management, and contract monitoring that is other than the routine required monitoring. Include a description of the implementation or planned implementation of the DSHS Standards of Care and the Standards of Care monitoring tools.
2. Describe community input and needs assessment activities that will occur during the reporting period. Activities may include the examination of the current care delivery systems; assessment of client need for HIV core medical or supportive services; and assessments related to addressing unmet need populations (e.g. assessments of barriers to enrollment in care, examinations of linkage systems).
3. Describe activities that will occur during the reporting period designed to ensure that clients whom are currently in care and at risk for being lost to care, will be maintained in care. Include the names of the collaborative partners, processes and expected results or challenges resulting from these activities.
4. Describe activities that will occur during the reporting period designed to bring individuals who are out of care into the care system. Include any expected results or challenges resulting from these activities.
5. Describe the activities the Administrative Agency has in place to minimize lapsing funds for contracts. Provide any current policies regarding monitoring of subcontractor expenditures.



## **FORM D: HIV/SRVS WORK PLAN**

### **Contractor:**

*Address the required elements (see WORK PLAN Guidelines) associated with the services proposed in this renewal application. **A maximum of five additional pages may be attached if needed.***

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